
Editorial

Promoting Health Care Equity: Is Health Literacy a Missing Link?

The need to improve quality and achieve equitable care for all Americans remain critical goals, and several national initiatives are underway that are sponsored by the federal government (e.g., Value Driven Health Care, <http://archive.hhs.gov/valuedriven/index.html>) and through ongoing private efforts such as those of the Robert Wood Johnson Foundation (RWJF). Two examples of RWJF's efforts: the Brookings Institution is leading The High-Value Health Care Project (<http://www.healthqualityalliance.org/hvhc-project> to make valid, timely, consistent information about the quality and cost of health care widely available in the United States; and the Aligning Forces for Quality initiative (<http://www.forces4quality.org/welcome>) is designed to lift the overall quality of care in 17 communities across the country. A key component common to each of these efforts seeks to target reducing disparities and promoting equity in health care, with a central focus on the systematic collection of race, ethnicity, and primary language data by health care organizations to identify at risk populations. Although recognizing that limited health literacy is a key risk factor in the receipt of lower quality care and a contributor to health care disparities, these efforts do not currently focus on collecting data about populations at risk for low literacy skills—which we argue may overlook an important link in the efforts to redress inequities in health care.

Despite more than a decade-long focus on addressing disparities in health care, high value and high quality are not trademarks of our health care delivery system for many disadvantaged groups. Inequities in health care remain prevalent for the most vulnerable members of our society, particularly individuals who belong to racial/ethnic minority groups, with limited English proficiency (LEP), and with less educational attainment and limited literacy skills. These characteristics are not mutually exclusive; individuals from underserved populations often share aspects of all these vulnerabilities as a consequence of known inequities found in other systems in our society (e.g., the educational system). Yet lately, there has been increasing interest in promoting health literacy as an immediate strategy to reduce disparities and provide patient-centered care. Here, we highlight the intersection of limited

health literacy and disparities in health care as contributors to low-quality care, discuss opportunities for improvement in the health care delivery system, and propose the role health services researchers can play in getting us closer to our goal of a high quality and equitable health care system.

HEALTH LITERACY AS A MEDIATING FACTOR TO HEALTH DISPARITIES

During the past two decades, “health literacy” has emerged as an area of research inquiry with more than 1,600 related research articles, and the field of “health care disparities research” and concurrent literature is equally robust (Institute of Medicine (IOM) 2003). These fields overlap in their focus on factors that may lead individuals to make poor decisions about their health care, as illustrated by their definitions in the United States by the IOM and National Library of Medicine. Health literacy is the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Health care disparities are the “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention.”

These two fields share another common feature: while both have led to highly productive research enterprises and have amassed a vast body of evidence documenting the problem, neither field has yet been able to offer evidence of targeted, yet broadly applicable clinical interventions and tools to effectively aid health care providers and systems in identifying and responding to individuals marginalized by limited health literacy and health care inequities.

The National Assessment of Adult Health Literacy found that over one-third of men and women in the United States have limited health literacy skills and the rates are disproportionately higher for racial and ethnic minorities, those with less education and functional literacy skills, and LEP. As a result of these overlapping relationships, the IOM has called for the need to view health literacy in the context of language and culture.

Recent studies have begun to frame health literacy within a health disparities context, by demonstrating that limited adult literacy contributes to racial disparities in health outcomes. When we talk about racial and ethnic disparities in health care and adjust for multiple factors (education, severity of illness, insurance, site of care, etc.), we are making assumptions about what the drivers of disparities may be. To ignore literacy and health literacy in our

models may mean that we are not taking into account a critical explanatory factor of disparities in care (Paasche-Orlow and Wolf 2007). This is important, as reducing disparities in health care is one of the federal goals for both public health and for improving health care quality in the United States.

ASSESSING LITERACY TO ADDRESS DISPARITIES IN HEALTH CARE

How information is delivered to patients is an indicator of quality, and this maybe even more pronounced in ambulatory care settings where the patient, not the clinician, is responsible for carrying out medical instructions delivered during a potentially short visit (Wolf 2009). Mary Catherine Beach (2009) identified disparities in patient centeredness at the level of the clinical encounter as well as at the health system level, and Schillinger et al. (2004) found disparities in patient centeredness by health literacy with patients with lower health literacy reporting worse communication with their provider. Identifying populations and patients at risk is a critical first step in designing evidence-based, patient-centered practices that can be implemented at the individual and systems level.

Literacy Assessment at the Individual Level

To date, health literacy research has used crude measures of reading and numeracy skills to assess the construct. The two most commonly used assessments of literacy in health care settings are the Rapid Estimate of Adult Literacy in Medicine and the Test of Functional Health Literacy in Adults (Parker et al. 1995; Davis et al. 1998). These measures have been widely used primarily for research purposes to examine, for example, the extent and association of reading and numeracy to health outcomes. Each instrument has its strengths, but also has important limitations such as not measuring comprehension to being lengthy to implement (Osborn et al. 2007). More importantly perhaps is that, to date, the clinical utility of these assessments has been limited. Even the shortest versions have been viewed as disconnected from clinical care because they may not directly inform clinicians about how to integrate this information into the care of patients.

Yet measuring patients' understanding or comprehension could serve as formidable proxies for assessing health literacy in a more actionable format. The IOM has recognized that measures of health literacy are general approximations of reading skills, albeit within the context of health care, and

has recommended the development of new measures that better estimate patients' understanding and ability to act on health care information.

Perhaps the most lauded health communication intervention response for limited health literacy, the "teachback" technique, is one method to either confirm understanding or identify patients who have difficulty during the clinical encounter. Other tools, such as the Brief Estimate of Health Knowledge Action briefly assesses health knowledge and action regarding specific conditions such as HIV treatment and predicting nonadherence to HIV medications (Osborn et al. 2010). These techniques and tools have been developed to assess both patients' context-specific knowledge and self-efficacy to enact recommended behavior and may be more acceptable screening options for clinicians compared with tools that directly measure a patient's literacy abilities.

Despite its promise to help clinical discourse, it is important to note that clinical screening for health literacy is a controversial topic and many argue for universal precautions. Opposition to health literacy screening programs has primarily been based on the potential for inducing shame and stigma, coupled with a lack of viable responses. Even with the development of acceptable screening tools, directly screening for literacy in clinical settings may not be as relevant as measuring comprehension or understanding, which fall under the broader rubric of health communication. A number of factors in addition to health literacy can affect understanding, but assessing whether patients have adequate comprehension of health information has obvious clinical relevance.

Literacy Assessment by Health Care Organizations

The complexity of the health care system and how patients experience it is an important consideration in addressing health literacy and health care disparities. George Isham (2009), Medical Director and Chief Health Officer of HealthPartners in Minnesota, has stated that though data that assess the health literacy skills of individuals can be collected, there is no similar assessment at the level of health care organizations and their population served. "We lack the measurement tools to assess patient literacy in populations served by operating health care systems. Quality measures for improving health literacy are lacking." As such, the problem of low health literacy should perhaps be viewed less as a patient problem and more as a challenge to health care providers and health systems to reach out and more effectively communicate with patients.

Therefore, assessments of health care providers and systems might include patient perspectives on the quality of provider and staff communication and readability of patient and family-directed health materials. In addition, how well

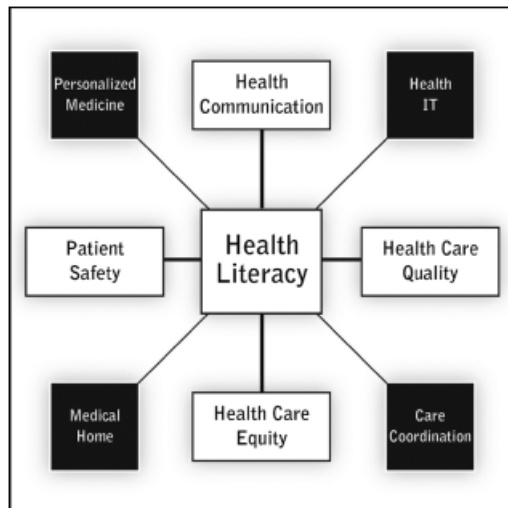
a health care system provides “anticipatory guidance” by instilling expectations of health care processes to patients and families in order to alleviate anxiety and support their ability to engage in requisite tasks is essential. Ideally, these targets could be incorporated into existing quality assessments by accrediting bodies, such as the Joint Commission or the National Committee for Quality Assurance, to foster organizational measures of health literacy.

Ultimately, health literacy assessment must account for both individual abilities and health care system complexities. Tools already exist to assess patients’ experiences with providers, including health literacy-related items centered on provider communication (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems Survey). The Agency for Healthcare Research and Quality also recently released, in April 2010, a health literacy toolkit to help health care systems improve the delivery of health information and care (DeWalt et al. 2010).

A RESEARCH AGENDA FOR ADDRESSING HEALTH LITERACY AND HEALTH CARE DISPARITIES

The health services research agenda for addressing health care disparities and promoting quality via health literacy requires several “next steps.”

Figure 1: The Intersection of Health Literacy with Health Care Improvement



First, viable, evidence-based tools are needed to support health systems' ability to identify individuals at risk for low health literacy. Existing research tools may be an important starting point. The article by Lee and colleagues in this issue of the journal provides an example of one such tool, which focuses on health literacy assessments for Spanish and English speakers. However, more innovative methods should be considered that would allow clinicians to accurately and efficiently engage in such routine screening.

Second, screening programs require robust intervention strategies among those identified as having difficulties. Therefore, the growing evidence supporting various strategies to successfully respond to health literacy concerns should be made readily available and broadly applicable. Additional research will also be necessary to continually expand this line of inquiry.

Third, health literacy and screening programs implemented in the vast array of health systems should incorporate comprehensive evaluation plans so we can quickly learn how best to implement and ultimately improve upon these activities.

Ultimately, if health care systems begin to routinely gather data on the health literacy skills of their patients and equivalent metrics become available for assessing organizations' health literacy responsiveness, we will have significant opportunities to rapidly develop innovative programs that can better accommodate those most marginalized by health literacy barriers. By incorporating a greater focus on health literacy, we move closer toward a patient-centered health care system (Figure 1).

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